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June 16, 2009

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

54 JUNE 30, 2009

SACHI A. HAMAI
EXECUTIVE OFFICER

TO: SACHI A. HAMAI
Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: JOHN F. KRATTLI
Senior Assistant County Counsel

RE: **Hermelinda Arcila, et al. v. County of Los Angeles**
Los Angeles Superior Court Case No. PC 042 869

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and the Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

JFK:rfm

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Hermelinda Arcila, et al. v. County of Los Angeles, Los Angeles Superior Court Case No. PC 042 869, in the amount of $325,000, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Department of Health Services' budget.

This medical malpractice lawsuit arises from treatment received by a patient while hospitalized at the Olive View Medical Center.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	Hermelinda Arcila and Raul Arceda Ruiz v. County of Los Angeles
CASE NUMBER	PC 042869
COURT	Los Angeles Superior Court North Valley District
DATE FILED	May 20, 2008
COUNTY DEPARTMENT	Department of Health Services
PROPOSED SETTLEMENT AMOUNT	$325,000
ATTORNEY FOR PLAINTIFF	Anthony N. Ranieri, Esq.
COUNTY COUNSEL ATTORNEY	Narbeh Bagdasarian
NATURE OF CASE	This is a medical malpractice case brought by Hermelinda Arcila and Raul Arceda Ruiz, for the injuries Hermelinda Arcila suffered when undergoing a removal of a benign lesion from her forehead at Olive View Medical Center ("OVMC"). On September 24, 2007, Ms. Arcila presented to OVMC for removal of a benign skin lesion on her right eyebrow. During the procedure the lower part of her face was covered by a surgical drape. The anesthesiologist involved in the procedure placed a mask on the patient's face, which was also covered by the drape, providing her with oxygen.

When the surgeon used an electrical device to stop the bleeding, the oxygen that was coming through the mask caught fire. The incident burned the skin under the oxygen mask and the skin around Ms. Arcila's eyes.

Hermelinda Arcila filed a case for medical malpractice against the County of Los Angeles. Her husband, Raul Arceda Ruiz, also filed an action for Loss of Consortium. The plaintiffs alleged that medical staff failed to utilize adequate procedures to prevent and/or caused the outbreak of a surgical fire during Ms. Arcila's mole removal procedure on September 24, 2007.

PAID ATTORNEY FEES, TO DATE	$27,811.50
PAID COSTS, TO DATE	$15,580.49

REVISED

Summary Corrective Action Plan

Date of incident/event:	September 24, 2007
Briefly provide a description of the incident/event:	On September 24, 2007, Hermelinda Arcila underwent removal of a benign skin lesion on her right eyebrow. Prior to the procedure, an oxygen mask was placed over Ms. Arcila's nose and mouth and Ms. Arcila's face was covered with a surgical drape exposing the eyebrow area. When the surgeon used an electrical device to stop the bleeding, the oxygen coming through the mask caught fire. The event burned Ms. Arcila's face under the oxygen mask and around the eyes.

1. Briefly describe the root cause of the claim/lawsuit:

- Failure to protect the patient from burn during surgery

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

- Appropriate personnel corrective actions were done
- A facility specific policy was revised to include a pause prior to the use of an electro-surgical device. The policy also includes methods for draping the face when oxygen is in use.
- Humidification gauges were moved into the surgical area for ongoing monitoring
- A system-wide survey was completed for the use of humidification monitors in the OR. All DHS facilities have humidification monitors in the ORs that are tracked daily.
- An advisory was developed by anesthesia for prevention and management of operating room fires that is consistent with the DHS "Prevention and Management of Surgical Fires and Burns" module.
- A system-wide module and post-test for "Prevention and Management of Surgical Fires and Burns" was distributed in 2006 to all DHS facilities and was revised and redistributed in 2008 to all DHS facilities. A revision insert was added in 2009 to include education related to communication during electro-surgical device use and facial draping when oxygen is in use. In addition to module distribution system-wide, the module is also being added to the DHS intranet, which is accessible to all DHS staff. The module will be required for all operating room staff system-wide.
- DHS staff system-wide are re-educated at least annually for fire prevention and management.

3. State if the corrective actions are applicable to only your department or other County departments:
(If unsure, please contact the Chief Executive Office Risk Management Branch for assistance)

☐ Potentially has County-wide implications.

☐ Potentially has implications to other departments (i.e., all human services, all safety departments, or one or more other departments).

X Does not appear to have County-wide or other department implications.

Signature: (Risk Management Coordinator)	Date: 5/27/09
Signature: (Interim Chief Medical Officer)	Date: 5/28/09
Signature: (Interim Director)	Date: 5-28-09